1.0 Description of the Service

Psychiatric Residential Treatment Facilities (PRTFs) provide non-acute inpatient facility care for recipients who have a mental illness and/or substance abuse/dependency and need 24-hour supervision and specialized interventions.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 Limitations

PRTF services are available to recipients under 21 years of age. Continued treatment can be provided until the recipient's 22nd birthday when medically necessary.

2.3 Special Provisions

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that provides recipients under the age of 21 with medically necessary health care to correct or ameliorate a defect, physical or mental illness or a condition identified through a screening examination. While there is no requirement that the service, product or procedure be included in the State Medicaid Plan, it must be listed in the federal law at 42 U.S.C. § 1396d(a). Service limitations on scope, amount or frequency described in this coverage policy do not apply if the product, service or procedure is medically necessary.

The Division of Medical Assistance's policy instructions pertaining to EPSDT are available online at http://www.dhhs.state.nc.us/dma/prov.htm.

3.0 When the Service Is Covered

3.1 Criteria for Admission

All of the following criteria are necessary for admission:

1. The child/adolescent demonstrates symptomatology consistent with a DSM-IV-TR (AXES I-V) diagnosis which requires, and can reasonably be expected to respond to, therapeutic intervention.
2. The child/adolescent is experiencing emotional or behavioral problems in the home, community and/or treatment setting and is not sufficiently stable either emotionally or behaviorally, to be treated outside of a highly structured 24-hour therapeutic environment.

3. The child/adolescent demonstrates a capacity to respond favorably to rehabilitative counseling and training in areas such as problem solving, life skills development, and medication compliance training.
4. The child/adolescent has a history of multiple hospitalizations or other treatment episodes and/or recent inpatient stay with a history of poor treatment adherence or outcome.
5. Less restrictive or intensive levels of treatment have been tried and were unsuccessful, or are not appropriate to meet the individual's needs.
6. The family situation and functioning levels are such that the child/adolescent cannot currently remain in the home environment and receive community-based treatment.

3.2 Continued Stay Criteria

All of the following criteria are necessary for continuing treatment at this level of care:

1. The child/adolescent's condition continues to meet admission criteria at this level of care.
2. The child/adolescent's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate.
3. Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated. Treatment planning should include active family or other support systems involvement, along with social, occupational and interpersonal assessment unless contraindicated. The expected benefits from all relevant treatment modalities are documented. The treatment plan has been implemented and updated, with consideration of all applicable and appropriate treatment modalities.
4. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.
5. If treatment progress is not evident, then there is documentation of treatment plan adjustments to address such lack of progress.
6. Care is rendered in a clinically appropriate manner and focused on the child/adolescent's behavioral and functional outcomes.
7. An individualized discharge plan has been developed which includes specific realistic, objective and measurable discharge criteria and plans for appropriate follow-up care. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met.
8. Child/adolescent is actively participating in treatment to the extent possible consistent with his/her condition, or there are active efforts being made that can reasonably be expected to lead to the child/adolescent's engagement in treatment.
9. Unless contraindicated, family, guardian, and/or custodian is actively involved in the treatment as required by the treatment plan, or there are active efforts being made and documented to involve them.
10. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated.
11. There is documented active discharge planning from the beginning of treatment.
12. There is a documented active attempt at coordination of care with relevant outpatient providers when appropriate.

3.3 Discharge Criteria

Criteria 1, 2, 3, 4 or 5, in addition to 6 and 7, are sufficient for discharge from this level of care:

1. The child/adolescent's documented treatment plan goals and objectives have been substantially met and/or a safe, continuing care program can be arranged and deployed at an alternate level of care.
2. The child/adolescent no longer meets admission criteria, or meets criteria for a less or more intensive level of care.
3. The child/adolescent, family, guardian and/or custodian are competent but non-participatory in treatment or in following the program rules and regulations. There is non-participation of such a degree that treatment at this level of care is rendered ineffective or unsafe, despite multiple, documented attempts to address non participation issues.
4. Consent for treatment is withdrawn, and it is determined that the child/adolescent or parent/guardian has the capacity to make an informed decision and does not meet criteria for an inpatient level of care.
5. .The child/adolescent is not making progress toward treatment goals despite persistent efforts to engage him/her, and there is no reasonable expectation of progress at this level of care nor is it required to maintain the current level of function.
6. The child/adolescent can be safely treated at an alternative level of care.
7. An individualized discharge plan with appropriate, realistic and timely follow-up care is in place

4.0 When the Service Is Not Covered

PRTF services are not covered when the medical necessity criteria listed in **Section 3.0** are not met.

Medicaid does not reimburse for services that duplicate another provider's service.

PRTF services that are ordered by the court are not covered when medical necessity criteria are not met.

PRTF is not covered when the primary issues are social or economic, such as placement issues.

5.0 Requirements for and Limitations on Coverage

5.1 Certification of Need

Federal regulations require a Certification of Need (CON) be completed on or prior to admission to a PRTF facility when the recipient is Medicaid-eligible or Medicaid is pending. The CON:

- Must be done concurrently with the Medicaid application, when the application is done during the stay. The independent utilization reviewer must be contacted immediately to begin the review process.
- Must be completed by an independent medical team, including a qualified physician.

- Cannot be retroactive.
- Must meet all federal requirements.
- Must certify that:
  - Ambulatory care resources within the community are insufficient to meet the treatment needs of the recipient.
  - The recipient requires services on an inpatient basis under the direction of a qualified physician.
  - Services can reasonably be expected to improve the recipient condition or prevent regression.

The last dated signature on the CON form determines authorization for payment.

A copy of the CON must be maintained in the recipient's medical record.

5.2 Therapeutic Leave

Each Medicaid eligible consumer who is occupying a psychiatric residential treatment facility bed for which the North Carolina Medicaid Program is then paying reimbursement shall be entitled to take up to 45 days of therapeutic leave in any calendar year from any such bed without the facility in which the bed is located suffering any loss of reimbursement during the period of leave. Therapeutic leave is also limited to no more than 15 days within one calendar quarter (three months).

1. The taking of such leave must be for therapeutic purposes only, and must be agreed upon by the consumer's treatment team. The necessity for such leave and the expectations involved in such leave shall be documented in the consumer's treatment/habilitation plan and the therapeutic justification for each instance of such leave entered into the consumer's record maintained at the Residential Facility's site.
2. Therapeutic leave shall be defined as the absence of a consumer from the residential facility overnight, with the expectation of return, to participate in a medically acceptable therapeutic or rehabilitative facility as agreed upon by the treatment team and documented on the treatment/habilitation plan.
3. Facilities must reserve a therapeutically absent consumer's bed for him, and are prohibited from deriving any Medicaid revenue for that consumer other than the reimbursement for that bed during the period of absence. Facilities shall be reimbursed at their full current Medicaid bed rate for a bed reserved due to therapeutic leave. Facilities shall not be reimbursed for therapeutic leave days taken which exceed the legal limit.
4. No more than five consecutive days may be taken without the approval of the consumer's treatment team.
5. Facilities must keep a cumulative record of therapeutic leave days taken by each consumer for reference and audit purposes. In addition, consumers on therapeutic leave must be noted as such on the facility's midnight census. Facilities shall bill Medicaid for approved therapeutic leave days as regular residence days.
6. The official record of therapeutic leave days taken for each patient shall be maintained by the State or its agent.
7. Therapeutic leave is not applicable in cases when the therapeutic leave is for the purpose of receiving inpatient services or any other Medicaid-covered service in the facility of current residence or in another facility. Therapeutic leave cannot be paid when Medicaid is paying for any other 24-hour service.

8. Transportation from a facility to the site of therapeutic leave is not considered to be an emergency; therefore, ambulance service for this purpose shall not be reimbursed by Medicaid.

6.0 Providers Eligible to Bill for the Service

PRTF programs:

- Must be under the direction of a board-eligible or certified child psychiatrist or general psychiatrist with experience in the treatment of children.
- The Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation must accredit the program as a residential treatment facility.
- Hospital licensure is required if the treatment is hospital based.

7.0 Additional Requirements

Documentation of PRTF services must meet both the requirements of the accrediting body and Medicaid guidelines.

Utilization reviews, including initial and continuing stay authorizations, are performed by an independent utilization review contractor. The utilization review contractor notifies the fiscal agent of the certified days.

8.0 Billing Guidelines

Reimbursement requires compliance with all Medicaid guidelines including obtaining appropriate referrals for recipients enrolled in Medicaid Managed Care programs.

8.1 Claim Type

Providers must bill services on the UB-92 claims.

8.2 Diagnosis Codes that Support Medical Necessity

Providers must bill the ICD-9-CM diagnosis code to the highest level of specificity that supports medical necessity.

8.3 Billing Codes

Providers must code service in form locator 42 with the revenue code (RCC) 911 billed as one unit per day. A recipient is permitted up to 45 days of therapeutic leave per calendar year from the facility without the facility losing reimbursement.

8.4 Reimbursement Rate

Providers must bill their usual and customary charges.

9.0 Policy Implementation/Revision Information

Original Effective Date: December 1, 2001
Revision Information: September 1, 2006

Date	Section Revised	Change
9/1/05	Section 2.0	A special provision related to EPSDT was added.
12/1/05	Section 2.3	The web address for DMA's EDPST policy instructions was added to this section.
1/1/06	Section 3.1	The section was revised to clarify the criteria for admissions.
1/1/06	Section 3.2	The section was revised to clarify the criteria for continuing treatment..
1/1/06	Section 3.3	The section was revised to clarify the criteria for discharge.
5/1/06	Attachment A	The level of care and initial and continuing authorization criteria for Level D services was deleted from the policy.
9/1/06	Section 5.2	Requirements and limitations related to therapeutic leave were added to the policy, effective with CMS date of approval, 8/19/2004.